

TESTIMONY FROM RICHARD KREINER

02/28/2007

Good morning Mr. Chairman and members of the Committee.

My name is Richard Kreienr and I am a self-employed carpenter. In 1984, my wife and I built our home in Attica, Michigan and began working together in a small carpenter business. We did not advertise, but relied upon our reputation in Lapeer County as good carpenters and word-of-mouth referrals. I did the heavy work, and my wife assisted. We did not have employees. By keeping the overhead low and working hard, we lived a comfortable life.

We owned a ½ ton pick-up truck and carpentry tools. In our business, we built additions, replaced roofs, did siding, put on roofing shingles, rough carpentry and some finished carpentry. We paid our taxes and our insurance. On October 5, 1998 our lives changed as a result of an automobile accident.

I was driving my ½ ton 1979 pick-up truck when Mr. Fischer pulled out with his ½ ton pick-up truck from a plaza parking lot into the path of my truck. I turned hard to the right to avoid striking Mr. Fischer's drivers side cab and slammed into the bed of his ½ ton pick-up truck. My truck sustained \$4,000.00 in damage and was undriveable.

I reported the accident to the Citizens Insurance Company that insured my truck. At first, I did not think I was seriously injured, but the next day my right hip and leg began to ache and throb.

When the aching and throbbing continued for a few days, I went to my family doctor who prescribed medication and physical therapy. I attended physical therapy, but my right hip and right leg only became worse.

My family doctor referred me to Dr. Fram, a neurologist, who took an MRI of my back and tested the nerves from my back down my leg. The neurologist advised that I sustained a back injury that injured the nerves from my back going down into my hip and right leg. My neurologist prescribed additional pain medications and physical therapy, provided me with a series of injections into my spine and gave me a back brace to wear. In addition, my neurologist also advised that I should lift no more than 15 pounds and avoid repetitive bending and twisting with my low back injury. I have attached my medical records from Dr. Fram's office and ask that they be accepted as part of the record.

Because of our business, I could not quit working. My wife and I worked together and if I quit, she would have to quit. Furthermore, I live in a small town. If the folks in my community believed that I was disabled from working as a carpenter, my wife and I would not have been able to continue our business.

I decided to continue working despite my doctor's restrictions by wearing a back brace, taking pain medication before and after work, reducing my work hours to 5 to 6 hours per day, taking additional days off and hiring an employee to do the heavy work that neither I nor my wife could perform. I discovered that I could lift up to 80 pounds with pain and

could stand on a ladder for approximately 20 minutes before the low back and right leg forced me to discontinue working.

In addition, I also discovered that I could walk up to a mile at a time before my low back, right hip and right leg pain became so painful that I had to rest. As a consequence, I discontinued rabbit hunting and only deer hunted with an ATV. I would use the ATV to get to the hunting site and then would use the ATV to drag the deer out.

I filed suit against Mr. Fischer who caused the accident because I believed that I should be compensated for my injuries and the pain and suffering that I have experienced.

I gave a deposition to Mr. Fischer's attorney from the Farm Bureau Insurance Company. In my deposition, I testified truthfully that I had returned to work with a back brace, that I worked beyond my physician's restrictions so that I could continue my business and that I had reduced my hours and work habits so that I could continue working with my wife. Although my business did suffer, I and my wife were still able to work.

The Farm Bureau Insurance Company's attorneys videotaped my wife and I while we were working. The videotape was consistent with my testimony. However, the videotape did not show the back brace that I was wearing under my clothes, the pain medication that I had taken the morning before I began working and that I took when I finished my work day, the various breaks during the day when my back could simply do no more, or the contractor that I hired to do the work that my wife and I could not do. The videotape had been unfairly edited to mischaracterize my abilities and, in my opinion, to deliberately mislead the judge.

From 1998 through 2003, the construction business in Lapeer County was very good. Because of my back injury, my wife and I were unable to work as much as we could have worked had I not been injured. While my tax returns may indicate that we made as much as we made the year before the accident, we should have been able to make much more. My back injury prevented me from taking full advantage of a good local economy. In addition, because I had to hire another contractor to do the work that my wife and I could not do, our profit margin was very small.

In 2003, I was forced to file bankruptcy because I could not work as hard or as long as I could before the accident. If I had not been injured, I do not believe I would have had to have filed bankruptcy.

After the accident, my no-fault insurance company, Citizens, advised that they would pay my medical bills for the injuries caused by the accident for the rest of my life. I was relieved to know that my medical bills would be covered because I did not have health insurance. However, the Citizens Insurance Company sent me to an insurance company doctor soon after the accident who said that he did not believe that I had an injury despite my own doctor's tests showing that I had a real injury. As a result of the insurance company's doctor's opinion, the Citizens Insurance Company terminated my medical benefits. My low back injury causing the pain into my right hip and right leg is real. My doctor confirmed my nerve injury with his tests. I have been in pain since the date of the accident and will continue to experience pain for the rest of my life. The insurance company's promise to pay my medical bills was a lie. I cannot afford to purchase prescription medication and have

been forced to purchase over-the-counter pain medication and double up on the dosage when my back and leg pain become excruciating.

After the Citizens Insurance Company terminated my medical benefits, the Farm Bureau Insurance Company's attorneys for Mr. Fischer were able to dismiss my case against Mr. Fischer before I had a chance to explain to a jury how the injuries I sustained in the accident changed my life because a judge found that my injuries were not serious enough even though my injuries were real. I believe if I would have had an opportunity to explain to the jury the nature of my injuries and how I and my wife have struggled to maintain our business despite my injuries that the jury would have found in my favor. However, if the jury had heard my case and found that my injuries were not serious enough to warrant compensation, I would have accepted the jury's decision. But I cannot accept a judge taking away my right to a jury trial on the basis of unfair evidence.

I am not a doctor. I am not a lawyer. I am a carpenter. I am not and will not be compensated for my time today. I have been advised by my attorneys that my case is over. I am here today to give you my testimony in the hopes that this Committee will have the courage to change the law so that no other Michigan resident will lose his or her rights to be fairly compensated following a motor vehicle.

I thank you for your time.

KREINER, Richard

Office Visit: 8-6-99

Mr. Kreiner was seen on followup visit because of continuous complaints of lower back pain with most of the pain localized to the right side, right leg pain mainly localized to the hip. Mr. Kreiner reported pain radiation to the right lower extremity mainly to the right thigh and back of the leg. The pain was aggravated by standing on his feet for any length of time, lifting, climbing a ladder, staying in one position for a long period of time. He denied visual changes, blurred vision, double vision, difficulties with swallowing.

Examination revealed the patient was alert and oriented to time, place and person. Neck was supple. Back examination was remarkable for mild tenderness and stiffness in the lumbar paravertebral muscles. Straight leg raising triggered low back tenderness at 50° on the right side and negative on the left side. Cranial nerves II-XII were grossly intact. Motor exam showed normal bulk and tone with normal strength. Deep tendon reflexes were 2+/4+ in the upper and lower extremities. Plantar response was flexor bilaterally. Sensation was intact to touch, position and vibration. Gait was independent. He was able to walk on toes and heels with minimal difficulties and tendency to limp on the right foot.

IMPRESSION:

Lower back pain secondary to lumbar strain and right L4 radiculopathy.

MRI examination of the lumbar spine from 8-17-99 showed degenerative disc disease at L3-S1 and grade I/II anterior spondylolisthesis of L5 in relation to S1.

RECOMMENDATIONS:

1. Mr. Kreiner will use back support garment during daily activity. He was advised to continue regular home back exercises and muscle strengthening exercises, daily walks as tolerated.
2. He was advised to avoid heavy lifting over 15 pounds, excessive bending and twisting. He is currently doing carpentry work, but he was advised to avoid heavy lifting.
3. He will use Skelaxin 400 mg one tablet twice and two tablets at bedtime as tolerated without developing side effects. He was given 124 tablets and two refills. He was informed of potential side effects with his medication.
4. Followup evaluation in three months or sooner if the necessity arises (11-5-99).

K. Fram, M.D., P.C.

KF:bd

Dictated but not always read.

KREINER, Richard

Office Visit: 10-9-98

Mr. Kreiner was seen on followup visit, and he reported no changes in his complaints of lower back pain. He complained of "hot and warm sensation" in the right leg. He denied GI or GU symptoms. He used Ultram for pain control with help. He did not feel any improvement in the pain with physical therapy, and he indicated if anything "it made it worse."

Examination revealed the patient was alert to time, place and person. Head and neck examination revealed mild tenderness at the occiput. There was full range of motion at the cervical spine. Back examination was remarkable for tenderness and mild stiffness in the lumbar paravertebral muscles more prominent at the lumbosacral junction. Straight leg raising triggered lower back pain and right hip pain at 45° on the right side and negative on the left side. Cranial nerves II-XII were grossly intact. Motor exam revealed normal bulk and tone with normal strength. Deep tendon reflexes were 2+/4+ in the upper and lower extremities. Plantar response was flexor bilaterally. Sensation was intact to touch, position and vibration. Gait was independent.

IMPRESSION:

Lower back pain secondary to lumbar strain and L4 radiculopathy.

RECOMMENDATIONS:

1. Mr. Kreiner will use Relafen 500 mg one tablet twice daily with meals if tolerated without developing side effects. He was given 60 tablets and one refill with usual discussion of potential side effects.
2. Home back exercises, muscle strengthening exercises, daily walks as tolerated.
3. Followup evaluation in two months or sooner if the necessity arises.

K. Fram, M.D.

KF:bd

Dictated but not always read.

cc: Citizens Insurance Company

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KREINER, Richard

Office Visit: 8-10-98

Mr. Kreiner was seen on followup visit, and he reported no changes in his complaints of lower back pain depending on his activity. The pain was aggravated by climbing heights, bending over, pushing and pulling. The pain was constant at times until he got off his feet. He did not report significant improvement in the pain following last visit's nerve block.


Examination revealed the patient was alert to time, place and person. Neck was supple. Back examination was remarkable for mild to moderate stiffness in the lumbar paravertebral muscles at the lumbosacral junction. Cranial nerves II-XII were grossly intact. Motor exam revealed normal bulk and tone with normal strength. Deep tendon reflexes were 2+/4+ in the upper and lower extremities. Plantar response was flexor bilaterally. Sensation was intact to touch, position and vibration. Gait was independent. He had tendency to limp on the right foot. Straight leg raising triggered low back tenderness at 65° on the right side and negative on the left side.

IMPRESSION:

Lower back pain secondary to lumbar strain and L4 radiculopathy.

RECOMMENDATIONS:

1. Mr. Kreiner will be started on physical therapy for three weeks at the Physical Therapy Center in Imlay City.
2. He will use Ultram 50 mg four times daily as needed for pain control. No prescription was provided.
3. Followup evaluation in two months or sooner if the necessity arises.


K. Fram, M.D.

KF:bd

Dictated but not always read.

cc: Citizens Insurance Company

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KREINER, Richard

Office Visit: 5-12-98

Mr. Kreiner was seen on followup visit because of continuous complaints of shooting pain in the right lower extremity. He complained of right hip pain radiating to the back of the right thigh and back of the right calf. The pain was aggravated by bending over, sitting or standing for any length of time. MRI examination of the lumbar spine on 4-17-98 showed spondylolisthesis of L5 in relation to S1, degenerative disc disease at L5-S1, degenerative disc disease at L3-4, L4-5.

Examination revealed the patient was alert to time, place and person. He was in no distress. There was minimal tenderness at the occiput. There was diffuse tenderness in the lumbar spine more prominent at the lumbosacral junction. Cranial nerves II-XII were grossly intact. Motor exam revealed normal bulk and tone with normal strength. Deep tendon reflexes were 2+/4+ in the upper and lower extremities. Plantar response was flexor bilaterally. Sensation was intact to touch, position and vibration. Gait was independent. He limped on the right foot. Straight leg raising triggered right sciatic pain at 60° on the right side. Left straight leg raising triggered no sciatic pain.

Lumbar paravertebral nerve block was accomplished by injecting 1 cc of Depo-Medrol and 3 cc of 0.5% Marcaine at L4-S1 under aseptic technique without difficulties. He tolerated the procedure well.

IMPRESSION:

Lower back pain secondary to lumbar strain and L4 radiculopathy, degenerative disc disease.

RECOMMENDATIONS:

1. Mr. Kreiner will continue to perform regular home back exercises, muscle strengthening exercises, daily walks as tolerated.
2. He will use Ultram 50 mg one tablet four times daily as needed for pain control. He was given 124 tablets and two refills. He was counseled about potential side effects with his medication.
3. Followup evaluation in three months or sooner if the necessity arises.



K. Fram, M.D.

KF:bd

Dictated but not always read.

cc: Citizens Insurance Company

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KREINER, Richard

Office Visit: 4-13-98

Mr. Kreiner was a 34-year-old right-handed man was seen at his request for evaluation because of complaints of right hip pain which started insidiously following an auto accident in November of 1997. There was pain radiation from the right hip to the back of the right leg between the hip and the calf with most of the pain localized to the calf muscle. He was the driver with his seatbelt on when he hit another car which pulled in front of him. He did not feel bad at the time of the accident, and he did not go to the hospital; however, he woke up the next morning with severe pain in the right leg. He also complained of numbness and tingling sensation in the right leg. The pain was aggravated by standing on his feet for more than five to six hours, heavy lifting and excessive work. The pain was relieved by nothing specific so far. He denied any GI or GU symptoms.

Past medical history was remarkable for above. He smoked one and one-half packs of cigarettes a day. He denied using alcohol. There was history of allergy to penicillin. Medications were none at this time. Family history was noncontributory.

Neurological Examination: The patient was alert and oriented to time, place and person. Mentation was intact. He followed commands appropriately. Head and neck examination revealed mild tenderness at the occiput. Cranial nerves II-XII were grossly intact. There was full range of motion at the cervical spine. Visual field was intact to confrontation. Fundi revealed no papilledema. Pupils were equal and reactive to light. Eyes moved in all directions with no nystagmus. Face was symmetrical. Palate elevated symmetrically, and uvula was midline. Tongue was midline with no atrophy or fasciculations. Motor exam revealed normal bulk and tone with normal strength. Deep tendon reflexes were 2+/4+ in the upper and lower extremities. Plantar response was flexor bilaterally. Sensation was intact to touch, position and vibration. Gait was independent. He limped on the right foot. Straight leg raising triggered pulling in the right hip muscles at 65° on the right side. Left straight leg raising triggered no pain.

MOTOR NERVE CONDUCTION STUDY:

The right peroneal nerve distal motor latency was 3.84 ms with action potential of 6.34 and 3.80 mv at the ankle and the knee respectively at velocity of 47 m/s. The right tibial nerve distal motor latency was 3.76 ms with action potential of 12.4 and 10.0 mv at the ankle and the knee respectively at velocity of 45 m/s.

The left peroneal nerve distal motor latency was 4.0 ms with action potential of 6.25 and 5.80 mv at the ankle and the knee respectively at velocity of 46 m/s. The left tibial nerve distal motor latency was 4.0 ms with action potential of 10.0 and 9.4 mv at the ankle and the knee respectively at velocity of 45 m/s.

Normally, the distal motor latency is less than 6.0 ms for the peroneal at velocity of 44-57 m/s and less than 5.2 ms for the tibial at velocity of 41-53 m/s.

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SENSORY NERVE CONDUCTION STUDY:

The right sural nerve distal sensory latency was 2.96 ms with action potential of 11.4 uv. The right medial plantar nerve distal sensory latency was 3.14 ms with action potential of 10.2 uv. The right superficial peroneal nerve distal sensory latency was 1.44 ms with action potential of 9.2 uv.

The left sural nerve distal sensory latency was 3.08 ms with action potential of 10.0 uv. The left medial plantar nerve distal sensory latency was 3.16 ms with action potential of 9.6 uv. The left superficial peroneal nerve distal sensory latency was 1.42 ms with action potential of 10.5 uv.

Normally, the distal sensory latency is less than 4 ms for the sural with action potential of 6-47 uv, less than 3.8 ms for the medial plantar with action potential of 10-40 uv and less than 1.6 ms for the superficial peroneal with action potential of 8-16 uv.

EMG NOTE:

A disposable monopolar needle electrode was used for sampling. The vastus medialis and lateralis of the quadriceps, tibialis anterior and posterior, peroneus longus, medial gastrocnemius, extensor digitorum brevis and lumbosacral paravertebral muscles were sampled bilaterally. Insertion activity was satisfactory. Voluntary contraction triggered expected numbers of motor units and most units had normal size, shape and configuration. The resting muscles showed fibrillations and positive sharp waves from the right quadriceps, peroneus longus, extensor digitorum and lumbar paravertebral muscle at L4-5 to the right side.

IMPRESSION:

Mr. Kreiner's examination, EMG and nerve conduction velocity study was abnormal and consistent with mild irritation to the right L4 nerve root (right L4 radiculopathy). Etiology may be related to disc herniation or disc fragment at L4-5.

RECOMMENDATIONS:

1. Mr. Kreiner was scheduled for MRI examination of the lumbar spine at Lapeer Hospital.
2. He will use Motrin one tablet three times daily as needed for pain control. He will use over-the-counter Motrin medication for now.
3. He will use Flexeril 10 mg one tablet at bedtime as needed for its muscle relaxing effect. He was given 30 tablets and one refill with usual discussion of potential side effects including but not limited to sedation effect, fatigue and tiredness, sedation effect, etc.
4. Mr. Kreiner was provided with instructions for home back exercises, muscle strengthening exercises and daily walks as tolerated.
5. Followup evaluation in one month or sooner if the necessity arises.

K. Fram, M.D.

KF:bd

Dictated but not always read.

cc: Citizens Insurance Company

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LAPEER REGIONAL HOSPITAL

Name: KREINER, RICHARD A Location: O OPD
Pt#: 0000080561 Hist#: 0000004231 DOB: 10/05/1963 Age: 034Y Sex: M
ADM. Phy.: FRAM, KARIM M MD FAM/REF: COMMUNITY PHYSICIAN
ORD. Phy.: JAMES, REESE ATT. Phy.:
Req#: 5025840 Adm Svc: OUT PATIENT DIAGNOSTIC C#: 0000004770
ADM. DIAG: LUMBAR SPINE DISC HERNIATION
COMMENTS:
Exam Requested: Schedule Date/Time: 4/17/1998
0007213 SPINE, LUMBAR PART EXAM

Final Report

8344

AP AND LATERAL FILMS OF THE LUMBAR SPINE DATED 4-17-98.

The examination was performed at 1004 hours.

History: Back pain exacerbated with motion.

The examination reveal anterior spondylolisthesis grade I of L5 in relation to S1 with bilateral spondylolysis in L5. There is narrowing of the L5-S1 intervertebral disc space.

The remainder of the intervertebral disc spaces and the vertebral body heights appear preserved. Facet degenerative changes are present at L5-S1. The pedicles and transverse process is not remarkable.

IMPRESSION

1. Anterior spondylolisthesis of L5 in relation to S1 with bilateral spondylolysis in L5 and degenerative disc disease at L5-S1.

JAMES, REESE J. D.O./RJJ
Electronically Released on 04/18/1998 at 07:58

***** -NOTE- *****
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Transcribed by DG on 04/18/1998 at 08:28
Dictated by JAMES, REESE J. D.O. on 04/17/1998 at 11:26

Name: KREINER, RICHARD A

Location:

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Pt#: 0000080561 Hist#: 0000004231

LAPEER REGIONAL HOSPITAL

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ORD. Phy.: FRAM, KARIM M MD ATT. Phy.:
Req#: 5025822 Adm Svc: OUT PATIENT DIAGNOSTIC C#: 0000004770
ADM.DIAG: LUMBAR SPINE DISC HERNIATION
COMMENTS:
Exam Requested: Schedule Date/Time: 4/17/1998
0008012 MRI LUMBAR SPINE W/O CONT

Final Report

8344.

MRI EXAMINATION OF THE LUMBAR SPINE DATED 4-17-98.

EXAMINATION PERFORMED AT 0930 HOURS.

HISTORY: Back pain and right lower extremity radicular symptoms.

High resolution, high field strength (1.0) tesla was performed in the axial and sagittal planes employing T1 and T2 weighted sequences.

The examination reveals a grade I/II anterior spondylolisthesis of L5 in relation to S1 with bilateral spondylolysis in L5. There is narrowing of the L5-S1 intervertebral disc space and there is loss of normal signal intensity from the L5-S1 intervertebral disc proper of degenerative disc disease. Facet degenerative changes are present at L5-S1.

The remainder of the intervertebral disc spaces and vertebral body heights appear preserved with minimal loss of normal signal intensity involving the lumbar intervertebral discs proper at L3-L4 and L4-L5.

The conus medullaris and visualized portion of the sacrum to the level of S2 is not remarkable.

No evidence of discrete lateralizing disc herniations are identified.

No discrete paraspinal soft tissue mass is noted.

IMPRESSION

Grade I/II anterior spondylolisthesis of L5 in relation to S1 with bilateral spondylolysis in L5.

2. Degenerative disc disease at L5-S1 and facet degenerative changes.
3. Mild degenerative disc disease at L3-L4 and L4-L5.
4. No evidence of lateralizing disc herniation is noted.

(Results continued on next page)

Name: KREINER, RICHARD A

Location: O OPD

Pt#: 0000080561 Hist#: 0000004231

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LAPEER REGIONAL HOSPITAL

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Req#: 5025822 Adm Svc: OUT PATIENT DIAGNOSTIC C#: 0000004770
ADM.DIAG: LUMBAR SPINE DISC HERNIATION
COMMENTS:

Exam Requested: Schedule Date/Time: 4/17/1998
0008012 MRI LUMBAR SPINE W/O CONT

Final Report

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JAMES, REESE J. D.O./RJJ
Electronically Released on 04/18/1998 at 07:58

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Dictated by JAMES, REESE J. D.O. on 04/17/1998 at 11:26

Name: KREINER, RICHARD A

Location: O OPD

Pt#: 0000080561 Hist#: 0000004231

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